CHAPTER 101
ESTABLISHMENT OF THE CAPITAL INVESTMENT FUND

SUMMARY OF AND RESPONSE TO PUBLIC COMMENTS

PUBLIC COMMENT PERIOD
DEADLINE FOR COMMENTS: DECEMBER 22, 2008

GOVERNOR'S OFFICE OF HEALTH POLICY & FINANCE

The Governor's Office of Health Policy and Finance received both oral and written comments on our proposed rule, Chapter 101, setting out the process for establishing the Capital Investment Fund. The proposed rule was made public on November 21, 2008, and public comments were accepted until December 22, 2008. A total of eight persons provided a range of comments on the proposed rule:

1. David Winslow, Maine Hospital Association
2. Paul Gray, MaineHealth
3. Doug Clopp & Mia Poliquin Pross, Consumers for Affordable Health Care
4. John Doyle, self
5. Andy McLean, Maine Medical Association
6. Kit St. John, Maine Center for Economic Policy (oral only)
7. Lee Myles, St. Mary's Medical Center
8. Eileen Skinner, Mercy

Herein is a summary of comments received, with our responses. Final CIF values are shown in the table below:

	2009 transition			2010-2012 effective period		
	Large	**Small**	**Total**	**Large**	**Small**	**Total**
Hospital	10,440,780	1,842,491	12,283,271	37,421,200	6,603,741	44,024,942
Non-Hospital	1,491,540	263,213	1,754,753	5,345,886	943,392	6,289,277
Total	11,932,320	2,105,704	**14,038,024**	42,767,086	7,547,133	**50,314,219**

Having a CIF at All

Comment: The CIF is an arbitrary limit and should be abolished, with CON review being the sole factor determining whether a project is approved in a given year [Mercy, St Mary's, Doyle].

Response: As we have stated in previous documents, the CIF is one of the only cost containment mechanisms available in state law, and it is important that it be preserved.

An analogy as to why it is beneficial to have both CON and the CIF is a family budget: there are many things that a family may need. However, a family on a budget must balance need with affordability.

The CON process determines whether a project will provide a benefit to the community. The CIF in effect establishes the maximum level of expenses added to the health care

system by capital projects deemed to be affordable over a given time period, under which projects can be reviewed, modified, and approved to ensure health system planning that delivers maximum value to residents across the state.

The CIF Formula

Comments: Setting the CIF at 0.31% of operating expenses is an acceptable compromise [CAHC, MECEP, MHA, St Mary's, MaineHealth]. However, a preferred option would be to size the CIF based on a thorough review of the current infrastructure and future need. A possibility would be to use the 0.31% formula for the 2009 transition year and the 2010-2012 three year CIF, which would afford time to conduct such a study for the sizing of the 2013-2015 CIF [MaineHealth, St Mary's, MHA].

Response: There are no resources to conduct such a study. Our proposal reflects what can be effectively implemented within existing resources. We will investigate the possibility of conducting such a study, but we note that it would be necessary to find resources to pay for such a study, as well as for multiple stakeholders to agree on how the study would be conducted and used in sizing future CIFs.

Three Year Element of the Proposal

Comments: The three year element of the proposal is an improvement over the current rule and is worth trying [St Mary's, MHA, MaineHealth, CAHC, MeCEP, Doyle]. It brings greater predictability. The one year transition period in 2009 before beginning the three year CIF is a good idea [St Mary's, MaineHealth].

However, the proposal is not likely to solve the "early bird" or "first in line" issue, and several very large projects and/or a combination of multiple medium-size projects in years one and/or two could effectively result in a moratorium in year three [Mercy, MaineHealth, Doyle], and the three year CIF could lead the CON unit to "push" projects from one year to the next, effectively creating a three year CON review period. GOHPF should examine the possibility of a three-year rolling approach so that a project is not disadvantaged by being reviewed in the third year [St. Mary's, Doyle].

Response: A primary goal in revising the CIF rule was to support providers' long term planning by ensuring predictability regarding the CIF amount.

In developing the proposed rule, we considered and ultimately decided against the three-year rolling approach precisely because it did not provide predictability. The rolling approach allows a project to draw upon that year's or the subsequent two years' 0.31% allocation regardless of when a project is approved (in other words, rather than having discrete three year periods with a beginning and an end, there is a moving three year window for debiting). This means that:

- year 1 decisions affect availability in years 2 & 3 (which, as shown in the table below, would range from a low of $17.4 mil to a high of $48.1 mil);
- year 2 decisions affect availability in years 3 & 4 (which would range from a low of $19.0 mil to a high of $52.5 mil);
- year 3 decisions affect availability in years 4 & 5 (which would range from a low of $20.8 mil to a high of $57.3 mil); etc.;

and the timing of when the available CIF becomes known is problematic from the standpoint of providers' planning:

- year 4 availability would not be known until year 3 decisions have been made by CONU;
- year 5 availability would not be known until year 4 decisions have been made by CONU; etc.

In other words, in any given year, providers cannot look into the coming several years and know how much will be available when.

Under our proposal, by contrast, predictability is achieved by the fact that the CIF in effect "resets" to a higher value every three years, with providers knowing its amount well in advance, giving all providers the opportunity to time their applications as they see fit. Our proposal to use 2009 as a one year transition period with the three year CIF starting in 2010 gives providers an opportunity to adjust to this new process.

However, we note that the ACHSD may revisit the CIF rule at the end of the first three year CIF to evaluate how the rule has worked on this and other fronts.

Predictability of CIF Availability in Non-Rolling vs Rolling Approaches ($ mil)

<table>
<tr><th rowspan="3"></th><th rowspan="3">non-rolling</th><th colspan="8">rolling</th></tr>
<tr><th colspan="2">year 1</th><th colspan="2">year 2</th><th colspan="2">year 3</th><th colspan="2">year 4</th></tr>
<tr><th>lo</th><th>hi</th><th>lo</th><th>hi</th><th>lo</th><th>hi</th><th>lo</th><th>hi</th></tr>
<tr><td>13.4</td><td rowspan="3">44.0</td><td rowspan="3">44.0</td><td rowspan="3">44.0</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>14.6</td><td rowspan="3">17.4</td><td rowspan="3">48.1</td><td></td><td></td><td></td><td></td></tr>
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Comment: The rule should include an opportunity to adjust the CIF value on an annual basis as circumstances change, with the opportunity for public input and GOHPF/ACHSD response, as under the current rule [St. Mary's, MHA, Doyle, MaineHealth].

Response: The purpose of the CIF is to serve as the affordability limit under which effective health system planning takes place. A major purpose of the rule revision was to provide greater predictability and to improve the way in which the CIF affects health system planning than in the original rule. Another purpose was to address issues regarding the original formula, which the provider community felt was unreasonable. Allowing annual increases in the CIF would defeat the purpose of a predictable affordability limit. However, we note that the ACHSD may revisit the CIF rule at the end of the first three year CIF to evaluate how the rule has worked on this and other fronts.

<u>Debiting Provisions</u>

Comment: It is unreasonable to cap the number of years to debit at three years [Mercy].

Comment: Supportive of capping the number of years to debit at three years [CAHC, MeCEP].

Response: One important advantage of a three-year CIF is that grouping three years together is a long enough period to accommodate large projects without needing to debit costs over multiple CIFs (as in the current rule, which has caused unpredictable spikes and valleys in available CIF amounts).

This is a more straightforward debiting mechanism that has several advantages over the current rule from both a cost containment and a planning perspective. Because the proposal in effect debits the costs of a project for a maximum of three years, the impact of large projects on the system is more accurately measured than in the current rule (which allows the costs of large projects to be debited over many years, obscuring their true impact on the system), and the CIF becomes a more meaningful limit (since the three year limit could not be over-spent, as CIFs can under the current rule), which consumers have pointed out is a fundamental objective.

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Comment: Any unspent balances at the end of a three-year CIF period should carry forward to the next period [MHA, Mercy].

Comment: Supportive of not carrying forward unspent balances at the end of a three-year CIF period [CAHC, MeCEP].

Response: One of the primary purposes of the CIF is to establish the maximum level of expenses added to the health care system by capital projects deemed to be affordable over a given time period. The fact that actual approvals might be less than that limit during one time period does not lead to the conclusion that it is acceptable to spend more than that limit in a subsequent time period. However, we note that the ACHSD may revisit the CIF rule at the end of the first three year CIF to evaluate how the rule has worked on this and other fronts; in so doing, the ACHSD could at that time recommend revising the rule to allow such a carry forward.

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Comment: If a project creates third year savings, there should be a credit to the CIF. Projects with no third year costs should not be subject to the CIF process [MHA, MaineHealth].

Response: We agree that there should be incentives for projects to create savings. However we do not agree that crediting the CIF would be appropriate, since a major purpose of the CIF is to create savings, and augmenting the CIF whenever a project creates savings would move away from that purpose. We believe the incentive to create savings is already met by the State Health Plan in that it gives higher priority to projects that "lead to lower cost of care / increased efficiency through such approaches as collaboration, consolidation, and/or other means."

However, to ensure that the CIF does not create disincentives for projects that create system savings, we will add clarifying language specifying that in the event that a project results in incremental operating costs for an applicant but is found by the Department to create net savings to the state's health care system as a whole – e.g., the merger of two hospitals, if such a merger were to create savings – there shall be no CIF debit. To strengthen the Department's ability to ensure effective health systems planning, however,

such projects – as well as projects with no third year operating expenses – will be reviewed as part of the Department's CIF small project review cycle.

Treatment of Debits from Prior CIFs and Transition CIF

Comment: The rule's reduction by $7,048,205 – which is the difference between what the first four CIFs would have been using the new formula versus the old formula – of the sum of debits from projects approved under the 2008 CIF undoes some of the success the CIF has had at containing costs when retroactively applied. If this concept is preserved in the final Rule, commenter suggests that the reduction should be lessened if St Mary's 2008 projects – which was still pending at the time of the hearing – ends up not being approved [CAHC, MeCEP].

Response: At the ACHSD's October 24th meeting, the Council reviewed three options regarding how to address outstanding debits from projects approved under the 2008 CIF:

1. Debit against the 1st three year CIF, which would reduce the available 2010-2012 CIF by the full amount of any outstanding debit.
2. Spread the debit against the next two three year CIFs, which would reduce the available 2010-2012 and 2013-2015 CIFs each by roughly half of any outstanding debit.
3. Waive any outstanding debits, so that the available 2010-2012 and 2013-2015 CIFs would be unchanged from estimated amounts.

The Council recommended that option 1 would be too extreme to meet the goal of moving to a new CIF formula that all can agree on, and it ultimately agreed on compromise version of option #2: retroactively calculating the first four CIFs using the new formula (0.31% of operating expenses) and then reducing the debit for 2008 projects by the difference between what the first four CIFs would have been using the new formula versus the old formula. The Council recommended that this is a reasonable compromise and is consistent with the purpose of the CIF in general as well as the new rule: it recognizes that the rule deems 0.31% as an acceptable CIF level, but also does not waive past debits beyond that amount.

St. Mary's project was approved December 17, 2008.

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Comment: It would be a more effective cost containment approach to debit 2009 projects against the 2009 CIF after – not before, as in the proposed rule – debiting 2007 and 2008 projects against the 2009 CIF. Similarly, costs from 2009 projects should not be permitted to (a) exceed the 2009 CIF, and (b) be debited against the 2010-2012 CIF [CAHC].

Comment: Not only should 2009 projects be debited against the 2009 CIF before debiting 2008 projects against the 2009 CIF, as in the proposed rule, but the 2010-2012 CIF should not be reduced due to any debits from 2008 or 2009 projects. To do otherwise would defeat a purpose of this rule revision [MaineHealth].

Response: The ACHSD's rationale for recommending that debits from the 2008 CIF be reduced by $7,048,205 was that in order to successfully transition to a new CIF process, it is necessary to strike a balance that recognizes that costs from already-approved projects should be debited, but that those debits should not result in inordinate reductions to availability of CIF amounts from the new 0.31% formula. We believe that our proposal's

treatment of 2007, 2008, and 2009 debits is consistent with this reasoning and that it strikes the proper balance between the positions of these two stakeholders as we transition from the old to the new CIF. The one change we have made from the proposed rule is to amend treatment of the debits of 2009 projects so that, if they do exceed the available 2009 CIF, the remaining amount is debited over both the 2010-2012 CIF *and* the 2013-2015 CIF (so as to be consistent with the proposed rule's debiting remaining debits from 2008 projects over the 2010-2012 and the 2013-2015 CIFs).

Other

Comment: The CIF should only apply to such projects as new services and discretionary department renovations. In contrast, replacement projects, when due to deteriorating infrastructure, patient quality of care and cost inefficiencies, should not be subject to the CIF, because: (1) "it is unlikely that the statewide need for replacement projects can be effectively anticipated in setting the CIF;" and (2) "it will likely take only one major replacement facility project to exhaust the entire CIF for a three year term" [Mercy].

Response: Exempting replacement costs from the CIF was considered by the ACHSD but rejected because inherent in any replacement are decisions about how much to "upgrade" what is being replaced, and to exempt anything that the applicant characterizes as replacement would undermine the CIF's ability to limit cost increases attributable to such upgrades. The Council also looked into whether it would be possible to parse out how much of a given project's costs can be considered "truly replacement" (for the purpose of exempting such costs from the CIF) versus an "upgrade" (for the purpose of subjecting such costs to the CIF), and determined that this would not be possible.

Regarding the comment that "it will likely take only one major replacement facility project to exhaust the entire CIF for a three year term," we note that the average third year costs of the four largest projects over the past 10 years (EMMC's 2008 New Patient Tower; CMMC's 2000 Cardiac Surgery Center, Mercy's 2005 Replacement Hospital, and MMC's 2003 Ob/Neonatal project) was $15.6 mil, well below the $44 mil 2010-2012 hospital portion of the CIF (with third year operating expenses inflated to 2011 to allow appropriate comparison to the 2010-2012 CIF).

Comment: The proposed rule does nothing to address concerns about geographic need [Mercy].

Response: Establishing a CIF process that encourages – but does not mandate – providers to gradually move towards planning on the same three-year planning cycle will enhance CONU's ability to ensure economic and orderly development of the state's health care system by giving them a bird's eye view of all the projects that providers around the state are planning over the mid to long term and helping CONU work with applicants so that projects can be adapted and approved to meet needs within the affordability limit.

This birds eye view will facilitate an important goal articulated in our September 19, 2008 Draft Capital Investment Fund Proposal document to the ACHSD: to ensure that meeting a true need in one part of the state does not crowd out meeting a true need in another part of the state.

We also note that the ACHSD had discussed the possibility of regional CIFs but rejected the idea based on the conclusion that while a regional CIF approach might have benefits, it

would be exceedingly difficult to define what those regions are and which providers belong in each.

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Comment: GOHPF and DHHS should work together to ensure that CON procedure rules comport with the CIF rule regarding such issues as: (1) definition and treatment of small vs large projects; (2) definitions of capital, operating, and total costs; CIF debits; etc. This CIF rule-making process should make clear that any provisions set forth in this rule supersede any inconsistencies in the CON procedures manual [St Mary's, MaineHealth, Doyle].

Response: We have clarified these definitions, and we and DHHS agree that CON rules should be updated to reflect these definitions.

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Comment: It appears that expenses from Acadia, Spring Harbor, and New England Rehab were excluded from the base upon which the 2009 CIF estimates that appeared in GOHPF documents was based [MHA].

Response: The commenter is correct. Acadia, Spring Harbor, and New England Rehab were inadvertently excluded. In issuing the 2009 CIF and subsequent CIFs, we have included them.

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Comment: It appears that bad debt expenses were excluded from the base upon which the estimates of the 2009 CIF appearing in GOHPF documents was based, even though GAAP considers bad debt as expenses [MHA].

Response: Bad debt is not an expense incurred by hospitals in providing services. Rather, it is revenue that a hospital at one point hoped to collect and had booked as revenue, but that it later writes off as uncollectable. The reason that GAAP treats bad debt as an expense is so that adjustments to the expense side of a balance sheet can be made when hospitals write off that previously anticipated revenue, thus allowing the expense and revenue sides of the balance sheet to balance. The MHDO template, by contrast, treats bad debt as an adjustment to revenue rather than as an expense, and the "total operating expense" field of the template therefore reflects what the hospital spent in providing services. Because the decision in this CIF rule is to set the CIF at a percentage of what hospitals spend in providing services, we decline to make the adjustment recommended by the commenter.

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Comment: Is the number provided in the explanatory memo for the 2010-2012 CIF the actual size of the 2010-2012 CIF, or is it an example? If it is an example, when will the actual 2010-2012 CIF be sized? [MaineHealth]

Response: The number provided in the explanatory memo for the 2010-2012 CIF was an example. The actual value of the 2009 and 2010-2012 CIFs are included on the first page of this document. Differences between the previous estimates and the final values are

attributable to (1) the final values being based on hospitals' FY07 electronic financial data filings with the MHDO, which had not been finalized when the estimates were made, so the previously released CIF estimates used trended FY06 filings; and (2) the inclusion of Acadia, Spring Harbor, and New England Rehab in the base upon which the CIF is calculated.

The 2013-2015 CIF will be sized no later than December 31, 2011.

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Comment: While the proposed rule allows for a transfer of unused small and large projects funds at the end of the three year CIF, the 15% set aside for small projects may not be sufficient in years one or two of the three year CIF. This could be addressed by (1) keeping small and large review cycles, but having one account against which all projects are debited; (2) permitting additional flexibility regarding the transfer of funds; and/or (3) allowing hospitals to ask DHHS to move projects from the small project to the large project cycle [MaineHealth, MHA].

Response: Regarding the first idea, we note that 2 MRSA 102(2) requires the "establish[ment of] large and small capital investment fund amounts" within the CIF. The purpose of this provision was to prevent large projects from crowing out small projects.

The commenter raises the possibility that the total debits of approved small projects could total 15% of the three year CIF in year one or two, which in effect places a moratorium on small projects until we know if there is any unspent balance from large projects at the end of the three year period -- in other words, they are crowded out by the fact that 85% of the three year CIF is reserved for large projects.

To address this possibility we have added language stating that in the event that the Small Project Amounts are fully depleted at any point prior to the end of the effective period, GOHPF Office, with advice from the ACHSD, shall review the CIF at that point and determine whether to allow some unspent balance from the Large Project Amount to be used by projects reviewed under the Small Project Amount at the point, and if so, what that amount shall be.

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Comment: There seems to be inconsistent language in Sections 1(L) & (N): It should probably read "<u>Non</u>-Hospital Small Project Amount…" after the first period in each subsection (underlined part is the addition) [CAHC].

Response: This was a drafting error and has been corrected.

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Comment: In spite of the inclusion in the rule of the 12.5% set-aside for non-hospital project, the commenter plans to introduce legislation to include the set-aside in statute [MMA].

Response: We believe having the set-aside in rule is sufficient.